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HOUSE BILL 2586
By McDonald

AN ACT to amend Tennessee Code Annotated, Title 56, relative to the adequacy of networks established to provide health care.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-32-204(e), is amended by adding the following language after the first sentence:

The applicant shall meet the network adequacy requirements established pursuant to Section 2 of this act.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 32, Part 2, is amended by adding the following language as a new, appropriately designated section:

Section ___. (a) Each health maintenance organization shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access to health care services twenty-four (24) hours per day, seven (7) days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the health maintenance organization, including but not limited to:

(1) Provider-covered person ratios by specialty;

(2) Primary care provider-covered person ratios;

(3) Geographic accessibility;

(4) Waiting times for appointments with participating providers;

(5) Hours of operation; and

(6) The volume of technological and specialty services available to serve the needs of covered persons requiring covered technologically advanced or specialty care.

The network adequacy standards description shall be available to the commissioner upon request.

(b) In addition to establishing the standards required pursuant to subsection (a), the health maintenance organization's network, shall demonstrate the following:

(1) An adequate number of accessible acute care hospital services, within a reasonable distance or travel time, or both;

(2) An adequate number of accessible primary care providers, within a reasonable distance or travel time, or both; the standard for this subdivision shall be not more than thirty (30) miles or thirty (30) minutes;

(3) An adequate number of accessible specialists and sub-specialists, within a reasonable distance or travel time, or both; the standard for this subdivision shall be:

(A) For counties that are included within a metropolitan statistical area, as defined by the federal Office of Management and Budget; having a population of five hundred thousand (500,000) or more, the standard shall be not more than twenty (20) miles or twenty (20) minutes, so long as specialists or sub-specialists within such area are available and agree to the terms and conditions of the contract or plan; and

(B) For counties that are included within a metropolitan statistical area, as defined by the federal Office of Management and Budget; having

a population of five hundred thousand (500,000) or less, the standard shall be not more than thirty (30) miles or thirty (30) minutes;

(4) The procedures for making referrals within and outside its network that, at a minimum, must include the following:

(A) A comprehensive listing, made available to covered persons and health care providers, of the plan's network participating providers and facilities;

(B) A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services;

(C) Timely referrals for access to specialty care;

(D) A process for expediting the referral process when indicated by a medical condition;

(E) A provision that referrals approved by the plan cannot be retrospectively denied except for fraud or abuse;

(5) The process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in plans;

(6) The quality assurance standards, adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care;

(7) The efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(8) The system for ensuring the coordination and continuity of care for covered persons referred to specialty providers;

(9) Any other information required by the commissioner to determine compliance with the provisions of this part.

(c) In any case where the health maintenance organization has no participating providers to provide a covered benefit, the health maintenance organization shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.

(d) The health maintenance organization shall only market a network plan in a geographic area where network providers are accessible without unreasonable delay.

(e) In determining whether a health maintenance organization has complied with this section, consideration shall be given to the relative availability of health care providers, specialists and subspecialists in the service area under consideration. Relative availability includes the acceptance by the health care provider, specialist or subspecialist of the terms, conditions and fees offered under the contract or plan.

(f) No managed care plan shall deny or restrict in-network covered benefits to a covered person solely because the covered person obtained treatment outside the network. This protection shall be disclosed in writing to the covered person. Nothing in this subsection shall be construed to require a managed care plan to pay for any benefit obtained outside the plan's network unless the contract or certificate provides for that out-of-network benefit.

SECTION 3. This act shall take effect July 1, 1998, the public welfare requiring it.